

NOTE: Incomplete and / or unsigned requisitions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

Colorectal Cancer Screening Program Colonoscopy Referral Form

Markham Site Booking Line: (905) 472-7531
Fax: (905) 472-7598

Uxbridge Site Booking Line: (905) 852-9771 ext.5325
Fax: (905) 862-2005

Hospital MRN #: _____

Patient Name (Last, First): _____

Date of Birth (DD/MM/YYYY): _____ Sex: F M

Health Card #: _____ Version Code: _____

Address: _____ Postal Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

Email: _____

Appointment Date & Time: _____

Date:	Referring MD	Signature	MD Phone #
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Additional Reports to: _____

Spoken Language if Other Than English	Contact information for translator if required (Name & Number)
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Please note that if your patient does not speak /read English, he/she should be accompanied by an interpreter at the time of appointment

Indication - Patient must be asymptomatic and meet one of the following:

- 1. Positive FOBT (PF)
- 2. A first-degree relative had Colorectal Cancer (FD) Whom _____ Age at DX. _____
- 3. Scheduled recall procedure (the 2nd and all subsequent colonoscopies)

Medical History

- | | |
|--|--|
| <input type="checkbox"/> Abnormal Renal Function
<i>Most recent serum creatinine level:</i> _____ | <input type="checkbox"/> Endocarditis Prophylaxis required <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Diabetes Mellitus on Medication
<input type="checkbox"/> Oral Hypoglycemics <input type="checkbox"/> Insulin _____ | Indicated only for: |
| <input type="checkbox"/> Emphysema/Other Severe Pulmonary Disease | <input type="checkbox"/> Prosthetic heart valve |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Previous history endocarditis |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Congenital heart defect w / prosthetic material/device within 6 months |
| <input type="checkbox"/> Anticoagulation / Coagulation Disorder | <input type="checkbox"/> History of Adverse Reaction to Sedation or Anesthesia |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Previous Abdominal / Pelvic Surgery |

Medications: NONE

Allergies: NONE

- Past Medical History - see attached summary **Preferred Site:** Markham Uxbridge
- Colonoscopy and Consultation Requested**
- Next available appointment Dr: _____ Billing #: _____

